

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO

In re:

Case No.: 1:17 MD 2804

National Prescription Opiate Litigation

BRIEF OF *AMICI CURIAE* THE KENNEDY FORUM, AMERICAN
FOUNDATION FOR SUICIDE PREVENTION, DEPRESSION AND BIPOLAR
SUPPORT ALLIANCE, THE JED FOUNDATION, KENNEDY-SATCHER CENTER FOR
MENTAL HEALTH EQUITY, MENTAL HEALTH AMERICA, NATIONAL
ALLIANCE ON MENTAL ILLNESS, NATIONAL ASSOCIATION OF ADDICTION
TREATMENT PROVIDERS, NATIONAL COUNCIL FOR BEHAVIORAL HEALTH,
NATIONAL ASSOCIATION FOR BEHAVIORAL HEALTHCARE,
SCATTERGOOD FOUNDATION, AND WELL BEING TRUST
IN SUPPORT OF

THE CREATION AND FUNDING OF A NATIONAL PROGRAM FOR
MENTAL HEALTH CARE SYSTEM REFORM

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CORPORATE DISCLOSURE STATEMENT

None of the *amici* has a parent corporation. No *amici* issues stock. No publicly held corporation owns 10% or more of an *amici*'s stock.

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INTEREST OF *AMICI CURIAE*

*Amici*¹ have a strong interest in ensuring that the awards in this litigation result in “meaningful” reforms “to abate this [the opioid] crisis.” Judge Dan Aaron Polster, *In Re: National Prescription Opiate Litigation*, MDL No. 2804, No. 1:17-CV-2804 (N.D. Ohio 1/9/18)(Transcript at 411). To abate the crisis, *amici* believe, the nation needs “new systems in place” for treating both opioid addiction² and mental illness. *Id.* As *amici* explain below, improving mental health care is critical to reducing opioid use and opioid deaths.

Amici are national, non-profit organizations dedicated to advancing mental health care

¹ No party’s counsel authored this brief in whole or in part; no party or party’s counsel contributed money intended to fund the brief’s preparation or submission; and no person other than *amici* or their members or counsel contributed money that was intended to fund the brief’s preparation or submission.

² In this brief, *amici* use the terms “substance use disorder,” “addiction,” and “substance use” interchangeably.

and improving the lives of the millions of Americans affected by mental illness.

The Kennedy Forum, launched in celebration of the 50th anniversary of President Kennedy's signing of the landmark Community Mental Health Act, aims to achieve health equity by advancing evidence-based practices, policies and programming for the treatment of mental health and addiction. The Kennedy Forum is committed to providing leadership at all levels to unite the country around a common vision to improve the lives of individuals living with mental illness and addiction, and to promote behavioral health for all. A statement from former Congressman Patrick J. Kennedy concerning The Kennedy Forum and its vision is included herein as Appendix A.

The **American Foundation for Suicide Prevention** is dedicated to saving lives and bringing hope to those affected by suicide. In carrying out its mission, AFSP funds scientific research, educates the public about mental health and suicide prevention, advocates for public policies in mental health and suicide prevention, and supports survivors of suicide loss and those affected by suicide.

The **Depression and Bipolar Support Alliance** is the leading peer-focused mental health organization whose mission is "to improve the lives of people living with mood disorders." DBSA reaches over four million individuals with support, educational resources, and tools to help individuals living with mood disorders lead productive and fulfilling lives.

The Jed Foundation is a national nonprofit that exists to protect emotional health and prevent suicide for our nation's teens and young adults. It partners with high schools and colleges to strengthen their mental health, substance abuse and suicide prevention programming and systems. It equips teens and young adults with the skills and support to grow into healthy, thriving adults; and it encourages community awareness, understanding and action for young adult mental health.

The **Kennedy-Satcher Center for Mental Health Equity** in the Satcher Health Leadership Institute at Morehouse School of Medicine was jointly envisioned by the 16th U.S. Surgeon General, Dr. David Satcher, and former Congressman Patrick J. Kennedy. The Center works collaboratively toward equal treatment of mental health and substance use disorders by elevating parity, conducting research on mental health policy, and engaging stakeholders to advance mental and behavioral health equity.

Mental Health America is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all Americans. MHA has advocated throughout its history for access to effective mental-health services and support, without undue administrative barriers that prevent individuals from progressing in their recovery.

The **National Alliance on Mental Illness** is the nation's largest grassroots organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support, and research, and is steadfast in its commitment to raising awareness and building a community of hope for individuals living with mental illness across the lifespan.

The **National Association of Addiction Treatment Providers** is a professional membership society of addiction service providers and supporters. The Mission of NAATP is to provide leadership, advocacy, training, and member support services to ensure the availability and highest quality of addiction treatment.

National Association for Behavioral Healthcare advocates for behavioral healthcare and represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in more than 1,800 inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive

outpatient programs, medication assisted treatment centers, specialty behavioral healthcare programs, and recovery support services.

National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with its 3,326 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

The **Scattergood Foundation** believes major disruption is needed to build a stronger, more effective, compassionate, and inclusive society where behavioral health is central. The foundation: convenes thought leaders from behavioral health, philanthropy and advocacy organizations to make policy recommendations, delivers technical assistance and consultation to non-profits, and provides funding to mission-aligned organizations.

Well Being Trust is a national foundation focused on advancing the mental, social, spiritual health of the nation. Through its investments in clinical transformation, community, policy and advocacy, and social engagement, Well Being Trust aims to decrease deaths of despair, those lives lost prematurely to drugs, alcohol, and suicide.

ARGUMENT

I. The Opioid Crisis is Driving Life Expectancy Downward

The opioid crisis has had devastating effects. One of the starkest is that opioid overdoses have played a major role in ending, and then reversing, the steady improvement of life

expectancy in the U.S.³ Between 2014 and 2017, life expectancy declined across all ethnic and racial groups for the first time in six decades.⁴

Between 1999 and 2017, fatal drug overdoses, largely from opioid use, increased nearly fourfold among adults aged 25 to 64.⁵ While fatal overdoses appear to have peaked, they remain near all-time highs, exceeding all-time peak deaths from automobile accidents, homicides, and HIV/AIDS.⁶

Behind these statistics are hundreds of thousands of personal stories of individuals and families from every state, income group and age damaged by opioid addiction. Walter Bender, a Deputy Sheriff in Montgomery County, Ohio, described in *Time* magazine the impact on him of witnessing so much tragedy:

You kind of become cold to seeing somebody overdose...But seeing the families that are affected, their loved ones, actually seeing them on the scene, trying to care for their loved ones or friends. To see that, to see the children involved, the heartache, it's overwhelming. You also learn not to give up. So I talk to everybody out here...I just don't brush by them. They're a human being. A lot of things are lost in the world today, and humanity is one of them.⁷

II. There is a Relationship between Opioid Use and Mental Illness.

Multiple studies have documented a relationship between opioid use and mental health disorders. For example, one study found that 51% of all opioid prescriptions went to individuals

³ Anne Case & Angus Deaton, Rising, *Morbidity and Mortality in Midlife Among White Non-Hispanic Americans in the 21st Century*, 112(49) PROC. NAT'L ACAD. SCI. 15078 (2015), available at <https://www.pnas.org/content/pnas/112/49/15078.full.pdf>.

⁴ Steven Woolf and Heidi Schoomaker, *Life Expectancy and Mortality Rates in the United States, 1959-2017*, 322(20) JAMA (2019), available at <https://jamanetwork.com/journals/jama/article-abstract/2756187>.

⁵ *Id.*

⁶ Josh Katz and Margot Sanger-Katz, 'The Numbers Are So Staggering.' *Overdose Deaths Set a Record Last Year*, N.Y. TIMES, Nov. 29, 2018, <https://www.nytimes.com/interactive/2018/11/29/upshot/fentanyl-drug-overdose-deaths.html>.

⁷ The editors of Time, *The Opioid Diaries: Inside the epidemic that's ravaging America*, Time (2020), available at <https://time.com/james-nachtwey-opioid-addiction-america>.

with mental health disorders.⁸ People with mood and anxiety disorders are twice as likely to use opioids as people without mental health disorders.⁹ They are also three times more likely to misuse opioids.¹⁰ Forty-three percent of people in treatment for misusing prescription painkillers have a diagnosis or symptoms of a mental health disorder, most commonly depression or anxiety.¹¹

Several studies have also connected opioid use with increased suicidal ideation and deaths from suicide.¹² It can be difficult to separate overdose and suicide as causes of death.

The National Institute on Drug Abuse (“NIDA”), a research institute of the National Institutes of Health within the U.S. Department of Health and Human Services, recommends that individuals seeking help for substance use be evaluated for mental health conditions.¹³ When a mental health condition is present, NIDA advises, treatment professionals should address the substance use disorder and mental health condition together, rather than focusing on one or the

⁸ Matthew A. Davis, Lewei A. Lin, Haiyin Liu & Brian D. Sites, *Prescription Opioid Use among Adults with Mental Health Disorders in the United States*, 30(4) J. AM. BD. FAM. MED. 407, 410 (2017), available at <https://www.jabfm.org/content/jabfp/30/4/407.full.pdf>.

⁹ *Id.* at 407.

¹⁰ D. Feingold, S. Brill, I. Goor-Aryeh, Y. Delayahu and S. Lev-Ran, *The association between severity of depression and prescription opioid misuse among chronic pain patients with and without anxiety: A cross-sectional study*, 235(1) J AFFECT DISORD. 293-302 (August 2017), available at <https://www.ncbi.nlm.nih.gov/pubmed/29660645>.

¹¹ Elliot M. Goldner, Anna Lusted, Michael Roerecke, Jürgen Rehm & Benedikt Fischer, *Prevalence of Axis-I Psychiatric (with Focus on Depression and Anxiety) Disorder and Symptomatology Among Non-Medical Prescription Opioid Users in Substance Use Treatment: Systematic Review and Meta-Analyses*, 39(3) ADDICT. BEHAV. 520, 523-24 (2014).

¹² Maria Oquendo, President of the American Psychiatric Association, National Institute on Drug Abuse, National Institutes of Health, *Opioid Use Disorders and Suicide: A Hidden Tragedy* (Guest Blog), <https://www.drugabuse.gov/about-nida/noras-blog/2017/04/opioid-use-disorders-suicide-hidden-tragedy-guest-blog> (last updated Apr. 2017).

¹³ National Institute on Drug Abuse, National Institutes of Health, *Comorbidity: Substance Use Disorders and Other Mental Illnesses*, <https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses> (last updated Aug. 2018).

other.¹⁴ Despite this national guidance, only 9.1% of those with co-occurring mental health and substance use disorders receive treatment for both conditions.¹⁵

III. Funds Should be Earmarked to Drive Needed Mental Health Care System Reforms

The relationship between opioid addiction and mental health disorders makes it critical to address mental health when seeking solutions for opioid addiction and overdoses. This is true when it comes to treatment for individuals, improving the health care system, and making national policy.

For this reason, *amici* urge that funds that emerge from this litigation be earmarked for improvements in mental health care. *Amici* also recommend that earmarked funds be administered by an independent foundation, the board of directors of which would include representatives of the Plaintiff states and localities, individuals with lived experience, health care experts, and representatives of national advocacy organizations.

There is precedent for earmarking funds to promote changes in health care and health care policy. The resolution of these cases could produce similar results, which would extend far into the future.

The precedent for earmarking funds for systemic reforms is the Tobacco Master Settlement Agreement (MSA), which emerged from the lawsuits brought against cigarette manufacturers by 46 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. The MSA, signed in 1998, prohibited particular advertising and marketing practices, disbanded projects that spread misinformation about tobacco, and exposed to public view documents

¹⁴ *Id.*

¹⁵ National Institute on Drug Abuse, National Institutes of Health, Comorbidity: Substance Use and Other Mental Disorders, <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/comorbidity-substance-use-other-mental-disorders> (last updated Aug. 2018).

detailing the long history of tobacco companies' ignoring tobacco's known risks and targeting vulnerable populations.

In addition, the MSA earmarked funds to create the American Legacy Foundation (since renamed The Truth Initiative), with the mission of reducing tobacco use. The work of the Truth Initiative, an independent foundation, continues to this day. It conducts research and public education campaigns, including the widely proclaimed Truth Campaign.

The MSA earmarked \$1.7 billion from the settlement to fund The Truth Initiative.¹⁶ The Truth Initiative's work has been a major factor in reducing teen cigarette use from 23% in 2000 to below 4% today.¹⁷

The MSA also resulted in states and territories receiving over \$126 billion in un-earmarked funds between 1998 and July 2018.¹⁸ Little of this money was used to reduce tobacco use or its consequences. Less than 1% was used for tobacco use prevention or cessation programs.¹⁹ On the whole, the funds were used in politically expedient ways, including making up for revenue shortfalls in jurisdictions' budgets. Prevention and cessation programs received little support. Over time, fewer and fewer settlement funds were devoted to tobacco-related activities.

IV. Amici's Proposal

Amici urge that up to 50% of funds from this litigation be invested in a foundation that, like The Truth Initiative, would plan and implement systemic reform. Our nation's mental health system urgently needs broad, systemic reform. While many are working to secure such reform,

¹⁶ U.S. GOVERNMENT ACCOUNTABILITY OFFICE, STATES' USE OF MASTER SETTLEMENT AGREEMENT PAYMENTS, GAO-01-851, pp. 9-10 (June 2001), <https://www.gao.gov/assets/240/231942.pdf>.

¹⁷ Truth Initiative, <https://truthinitiative.org/who-we-are/our-impact> (last visited Jan. 16, 2020).

¹⁸ *Payments to States Inception Through July 19, 2018*, National Association of Attorneys General Tobacco Project, https://www.naag.org/assets/redesign/files/Tabacco/2018-07-25__Payments_to_States_Inception_through_July_19_2018.pdf.

¹⁹ *The Master Settlement Agreement: An Overview*, PUBLIC HEALTH LAW CENTER (January 2019), available at <https://publichealthlawcenter.org/sites/default/files/resources/MSA-Overview-2019.pdf>.

none has the resources to lead an effort on the scale required. The resolution of these cases presents an historic opportunity to invest in such leadership and advance the work of securing necessary systemic reform.

A foundation with such substantial funding could help our nation plan and build an effective and sustainable mental health system that meets the needs of all Americans.

The board of directors of The Truth Initiative includes state officials and public health experts.²⁰ *Amici* propose that, similarly, the board of the foundation funded through this litigation be comprised of representatives of the Plaintiff states and localities, individuals with lived experience, health care experts, and representatives of national advocacy organizations. Depending on its funding, the foundation's tenure could be indefinite or time-limited.

The creation and operation of the foundation could be supervised by the Court through the appointment of a special master. The special master should have experience in supervising the distribution of large sums. The special master and the new foundation would work together to establish the foundation's policies and procedures for public input, planning, expenditures (including grantmaking), transparency and public reporting, and evaluating activities. The foundation's work would include both foundation-created initiatives as well as funding the initiatives of other organizations.

Amici propose that the foundation promote systemic change through three overlapping strategies:

1. Supporting evidence-based services;
2. Supporting infrastructure development, including the education and training of personnel; and
3. Supporting organizations working on systemic policy change.

²⁰ Truth Initiative, <https://truthinitiative.org/who-we-are/our-team> (last visited Jan. 16, 2020).

Supporting Evidence-Based Services

The foundation would promote the development and expansion of evidence-based services, that is, services that research and experience have shown to be effective. This could include supporting pilots that test innovative practices and bringing to scale practices that have already been demonstrated to be effective in preventing, diagnosing, or advancing recovery from mental health and substance use disorders.

Grantees could be governments, non-profit service providers, organizations promoting mental health care reform or public-private partnerships. Potential requirements for funding could include:

- Demonstrated need and potential benefit;
- Alignment with a public health approach;
- Plan for sustainability of services, including utilizing public and private insurance payors; and
- Commitment of involved jurisdictions to system reform.

Supporting Infrastructure Development

The foundation would assist states and localities and public-private partnerships with the development of infrastructure to promote and sustain evidence-based practices. This infrastructure could include the education and training of personnel. Requirements for receiving funding for infrastructure development would be similar to the requirements for receiving funding to develop or expand evidence-based practices.

Organizations Working on Systemic Policy Change

The foundation would also support policy development and advocacy. Too often, innovative solutions and promising practices from around the country stay siloed. The foundation would help ensure, through high-quality policy work, these solutions and practices

are identified and promoted. The foundation could undertake this work through its own organization, and would also fund a variety of federal, state, and local policy groups across the country. Requirements for funding could include:

- Demonstrated need and potential benefit; and
- Demonstrated expertise in policy development and/or policy advocacy.

Appendix B identifies a broad range of systemic reforms that could be advanced by the foundation, including reforms to improve prevention of and recovery from addiction.

V. Parity is Key to Prevention, Treatment, and Recovery

“Parity” means giving people with mental health and substance use disorders the same access to and quality of care as people with physical health conditions.

The Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Law) is landmark legislation designed to further this goal by reversing insurers’ long history of discrimination in coverage against mental illness and addiction and, in conjunction with the Affordable Care Act, mandating equitable coverage.²¹ State-based parity laws, used as models for the Federal Parity Law, had demonstrated that equitable coverage increased rates of treatment, including by increasing the number of treatment providers that accepted insurance.²² The Federal Parity Law has had similar results, including driving down out-of-pocket expenses for individuals seeking mental health and addiction care.²³

²¹ Kirsten Beronio et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (February 2013), available at https://aspe.hhs.gov/system/files/pdf/76591/rb_mental.pdf.

²² Hefei Wen et al., *State Parity Laws and Access to Treatment for Substance Use Disorder in the United States: Implications for Federal Parity Legislation*, 70(12) JAMA PSYCHIATRY 1355, 1359 (2013), available at <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1761269>.

²³ Vanessa Azzone et al., *Effect of Insurance Parity on Substance Abuse Treatment*, 62(2) PSYCHIATRIC SERV. 129 (2011), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3250065/pdf/nihms344166.pdf>.

More progress could be made if the federal government and state regulators vigorously enforced the law. Data from the leading international actuarial and consulting firm Milliman, based on approximately 37,000,000 covered lives, shows disturbing disparities in access to care. Milliman found that for both inpatient and outpatient care, mental health and addiction care occurred out-of-network five times more often than medical and surgical care, underscoring the inadequacy of insurers' networks.²⁴ These disparities, which worsened over the five-year period (2013 to 2017) Milliman studied,²⁵ are explained in large part, according to Milliman, by the fact that providers of physical health care are reimbursed far better, over 20% better, than providers of mental health and addiction care.²⁶

During the period studied, spending on treatment for addiction was only 1% of insurer spending on health care, illustrating a disconnect with federal parity policy and between insurers' reimbursement practices and the needs of their enrollees.²⁷

Insurers across the country (both commercial and Medicaid-managed care) are limiting coverage for mental health and addiction treatment by (a) reimbursing providers at low rates, (b) making in-network care unavailable for their members, (c) placing barriers to getting care approved once a provider is found, and (d) imposing higher out-of-network patient cost-sharing requirements. A lack of transparency makes it difficult, if not impossible, for insured individuals to protect their rights.

²⁴ Milliman Research Report, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf, at 10 (Nov. 19, 2019).

²⁵ *Id.* at 6.

²⁶ *Id.* at 13-14.

²⁷ *Id.* at 17.

These practices, which profoundly affect access to care, must end. The Kennedy Forum and its partners are leading efforts to ensure that parity is implemented in reimbursement systems and in the delivery of care.

CONCLUSION

This litigation presents an historic opportunity to create a national program for mental health care system reform. Better mental health care is a critical component in addressing opioid addiction and opioid-related deaths.

An independent foundation should be created and funded to ensure that improved mental health care is a part of the remedy that emerges from these opioid-related cases. Such an initiative would strengthen our nation's mental health care system and empower it to reduce the suffering and loss caused by the opioid crisis. It would aid in meeting the needs of individuals at risk of opioid addiction due to mental illness, averting them from being added to the list of victims.

Respectfully submitted,

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Appendix A

Statement of Former Congressman Patrick J. Kennedy

Unique Perspective to Address Crisis

My personal and professional journeys have blessed me with a unique perspective on what our country must do to combat discrimination, get people the services they need to treat their conditions and support recovery, and ensure that mental health and addiction are never considered separate from overall health – or separate from each other. While in Congress, I authored the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Law) and brought together a historic coalition of mental health and addiction advocates to help ensure its passage. This landmark law requires insurers to cover treatment for mental health and substance use disorders no more restrictively than treatment for illnesses of the body, such as diabetes and cancer. The Federal Parity Law has increased access to treatment and, in combination with the Affordable Care Act, has eliminated many discriminatory practices, though it has still yet to realize its full promise including because regulators across the country have failed to fully enforce it.

After leaving Congress, I opened up about my own story with mental health and addiction in *A Common Struggle: A Personal Journey Through the Past and Future of Mental Illness and Addiction*. I was overwhelmed by the outpouring of support from individuals sharing their own stories, reinforcing my view that this is a critical civil rights cause of our time. In 2013, I launched The Kennedy Forum on the 50th anniversary of President Kennedy's signing of the landmark Community Mental Health Act. Through our extensive network of partners, The Kennedy Forum leads a national dialogue on transforming the health care system by uniting mental health advocates, business leaders, and government agencies around a common set of

principles, including full implementation of the Federal Parity Law.

I am also a co-founder of One Mind, which accelerates scientific discoveries by supporting collaborative research that can be brought to scale to improve patients' lives. With its vision of healthy brains for all, One Mind funds patient-centered brain research, regularly convenes stakeholders to identify and solve problems in brain health, and advocates for research and policy that serves people with lived experience. Its One Mind at Work program is helping employers around the country prioritize mental health in the workplace to improve not only the lives of their employees, but also their bottom lines.

In 2017, I served as a member of President Trump's Commission on Combating Drug Addiction and the Opioid Crisis. In addition to the 56 recommendations put forward by the Commission,¹ I made public dozens of additional recommendations on the systemic changes needed to combat the opioid crisis.² My recommendations covered a full range of needed reforms from insurance coverage and early treatment to criminal justice and research. All were focused on advancing the ultimate goal for people with these conditions: recovery.

Realizing President Kennedy's Vision

The courts overseeing settlements relating to opioid manufacturers' role in fueling the crisis have a momentous opportunity in creating the mental health and addiction system we need. As President John F. Kennedy recognized when he signed the Community Mental Health Act into law in 1963, the United States had to end the inhumane and degrading treatment of people

¹ Gov. Chris Christie, Gov. Charlie Baker, Gov. Roy Cooper, Congressman Patrick J. Kennedy, Professor Bertha Madras, Ph.D. and Florida Attorney General Pam Bondi, *The President's Commission on Combating Drug Addiction and the Opioid Crisis*, The White House (Nov. 15, 2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf.

² *Recommendations of Congressman Patrick J. Kennedy to the President's Commission on Combating Drug Addiction and the Opioid Crisis*, THE KENNEDY FORUM (Oct. 2017), <https://chp-wp-uploads.s3.amazonaws.com/www.thekennedyforum.org/uploads/2017/10/PJK-recommendations-to-Opioid-Commission.pdf>.

with mental illness and provide services in community-based settings that recognized their humanity. Unfortunately, after President Kennedy's tragic death, community-based services never received the funding to realize his vision. Thus, while we have moved away from institutionalization in asylums, our country's abject failure to prevent, identify and treat mental health and addiction problems early has resulted in a new era of institutionalization that warehouses people with mental health and substance use disorders in jails and prisons, and confines far too many to the indignity of living on our streets.

That is why The Kennedy Forum has called for creating the system we need³ that is based on five key pillars:

1. Demand Better Outcomes through Quality and Transparency;
2. Ensure Access to Care through Insurance Parity;
3. Increase Access, Lower Costs, and Deliver Better Outcomes through Integration and Coordination;
4. Drive Collaboration to Create Better Results through Technology; and
5. Develop New Ways to Provide Earlier Interventions through Brain Health and Fitness.

Within each of these areas are innumerable policy and systems changes that are necessary to prevent, diagnose, treat, and support recovery from mental health and substance use disorders. These changes include those that must occur within existing systems and those that must break down the barriers between systems that inhibit wellness and recovery.

/s/ Patrick J. Kennedy II

³ The Kennedy Forum, *Kennedy Forum: The System We Need*, YouTube (Feb. 23, 2016), <https://www.youtube.com/watch?v=OtTvKqbVnhY>.

Appendix B

Recommended Systemic Changes to U.S. Mental Health and Addiction Care

Set forth below is a sample of the systematic changes to our country's mental health and addiction care that a private foundation could support. This is not a comprehensive list, but demonstrates the amount of work to be done. Further details can be provided if requested.

Parity and Health Insurance Accountability

For no other medical conditions besides mental health and substance use disorders have such a large proportion of patients been forced to pay out of pocket for the services they need. Indeed, after decades of discrimination and continued inadequate provider networks, far too many people needing mental health and addiction services have grown accustomed to this unfortunate reality. Likewise, mental health and addiction providers have become habituated to low payment rates from insurers, which they too often cannot accept and keep their doors open. Providers rely on discretionary grants from governments and foundations and donations from individuals to keep their doors open, a situation we would never accept for primary care or medical specialists. It is imperative that the opioid settlements should be put to work to help build sustainable financing for mental health and addiction care.

The Federal Parity Law promised to do just this by mandating that mental health and substance use care be paid for in the same way as medical and surgical care. While we have made progress, particularly with discriminatory quantitative limits (e.g., limits on the number of mental health visits per year) and financial requirements (e.g., different copays), mental health and addiction services are still subjected to insurers' purposely low reimbursement rates, narrow networks and restrictive non-quantitative treatment limitations (NQTLs, or managed care practices). As the recent Milliman and GAO reports show, state and federal regulators must do more to ensure compliance with the Federal Parity Law. There must be a network of independent

oversight and accountability across the country. The Kennedy Forum has extensive experiencing working with stakeholders across the country to advance compliance with the Federal Parity Act. Such a network could be modeled after the federal Fair Housing Initiatives Program, which funds organizations across the country to assist people who believe they have experienced housing discrimination in violation of the federal Fair Housing Act. Through \$38 million in annual funding, these organizations also promote awareness of fair housing laws and engage in “testing” of suspected illegal practices.¹

Other systemic changes that are needed to ensure compliance with the Federal Parity Law include:

- Provide the U.S. Department of Labor with the authority to issue civil monetary penalties for noncompliance;
- Require insurers to report on parity compliance;
- Require comparative claims data reporting;
- Provide patients with meaningful remedies through the appeals process and in the courts; and
- Implement lessons from *Wit v. United Behavioral Health* (UBH) regarding insurers’ flawed medical necessity criteria for mental health and addiction care.

Health Care – Responding to Opioid Crisis

Limit Inappropriate Opioid Prescribing

As has been very well documented, the number of opioid prescriptions skyrocketed

¹ *Fair Housing Initiatives Program*, U.S. Department of Housing and Urban Development, https://www.hud.gov/program_offices/fair_housing_equal_opp/partners/FHIP.

beginning in the late 1990s. In 1997, 74 milligrams of opioids were sold per person in the United States. A decade later, it was 369 milligrams – a 402% increase.² From 2006 to 2012, 72 billion oxycodone and hydrocodone pain pills were sold in the United States,³ making the U.S. the worldwide leader by far in prescription opioids per person.⁴ According to the CDC, people who become addicted to prescription opioids are forty times more likely to be addicted to heroin.⁵ Thus, it is critical to shut down the entry point of inappropriate prescription opioids, which can lead to even more deadly usage of heroin and powerful synthetic opioids like fentanyl.

Prescription Drug Monitoring Programs (PDMP)

PDMPs are essential to monitoring opioid prescribing by doctors and inappropriate usage by patients. While major steps have been taken to establish PDMPs around the country, the following steps should be taken to improve their functionality:

- Require PDMP usage to be reimbursed by Medicare and Medicaid;
- Create a user-friendly standardized PDMP system;
- Implement PDMP evidence-based practices; and
- Provide feedback to prescribers on prescribing metrics.

Limit Pills in Circulation

States should also take other measures to limit inappropriate prescribing and limit the number of opioid pills in circulation, which is particularly important to ensure that children and teens do not have access to leftover pills. These include:

² *Therapeutic use, abuse, and nonmedical use of opioids: a ten-year perspective*, Pain Management Center of Paducah, Paducah, KY, USA (Sep.-Oct. 2010) 13(5):401-35, <https://www.ncbi.nlm.nih.gov/pubmed/20859312>.

³ Scott Higham, Sari Horwitz and Steven Rich, *76 Billion opioid pills: Newly released federal data unmasks the epidemic*, The Washington Post (Jul. 16, 2019), https://www.washingtonpost.com/investigations/76-billion-opioid-pills-newly-released-federal-data-unmasks-the-epidemic/2019/07/16/5f29fd62-a73e-11e9-86dd-d7f0e60391e9_story.html?arc404=true.

⁴ *Opioids*, Organisation for Economic Co-operation and Development (May 2019), <https://www.oecd.org/health/health-systems/opioids.htm>.

⁵ *Today's Heroin Epidemic*, Centers for Disease Control and Prevention (July 7, 2015), <https://www.cdc.gov/vitalsigns/heroin/index.html>.

- Provide prevalent take-back programs;
- Allow prescribers to accept unused medications;
- Limit prescribing to seven-day courses for acute pain;
- Adopt CDC opioid guidelines for chronic pain;
- Eliminate payment barriers to non-opioid alternatives to pain management;
and
- Require providers to receive education on opioids and pain management.

Prioritize A Public Health Approach and Improved Linkages to Treatment

A public health approach is critical to combating the opioid crisis. In order to save lives and promote recovery, our country must prevent overdose deaths, reduce the harms associated with substance use, and improve linkages to treatment by meeting those with substance use disorders where they are. Preventing overdose deaths is of paramount importance, because each time a fatal overdose is prevented or reversed presents another opportunity for treatment and ultimate recovery.

Ensure Widespread Availability of Naloxone

Naloxone, an opioid antagonist that rapidly counters the effects of an opioid overdose, must be made widely available, particularly because naloxone has little to no effect if an individual has not used opioids. The following steps are needed to ensure the availability of naloxone:

- The U.S. Preventive Services Task Force should give naloxone an “A” for preventing fatal overdoses;
- Tie federal funding to first-responders carrying naloxone;
- Issue statewide standing orders for naloxone and allow third-party prescribing;

- Remaining 14 states should expand Medicaid under the Affordable Care Act;
- Co-prescribe naloxone with opioid prescriptions;
- Make naloxone available over the counter; and
- Pass naloxone versions of Public Access Defibrillation (PAD) laws.

Prioritize Other Strategies to Save Lives

Naloxone is critical to saving lives, but other strategies are also needed to reduce the harm of opioid and other substance use. These include:

- Make fentanyl testing strips widely available for free;
- Legalize and fund syringe exchange programs (SEP);
- Leverage SEPs to reduce harms and increase access to treatment; and
- Support mobile outreach teams.

Remove Barriers to Addiction Treatment and MAT

Our country must also remove barriers to substance use disorder treatment, particularly medication-assisted treatment (MAT), the gold-standard of opioid use disorder treatment. Tragically, 90% of people needing addiction treatment do not receive treatment.⁶ As the name suggests, MAT combines a medication (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies. MAT is highly effective at treating opioid use disorder.⁷

Hold Payors Accountable for Covering Addiction Treatment

Public and private payors are critical to expanding access to substance use disorder treatment, including MAT. Consequently, the following actions should be taken to expand

⁶ *Addiction is treatable*, Center on Addiction (Apr. 14, 2017), <https://www.centeronaddiction.org/addiction-treatment>.

⁷ *Effective Treatments for Opioid Addiction*, National Institute on Drug Abuse (Nov. 2016), <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction>.

coverage:

- Cover all types and formulations of MAT;
- Prohibit prior authorization or step therapy requirements for MAT;
- Require use of ASAM Criteria for substance use disorder level of care determinations;
- Set minimum network adequacy requirements for addiction;
- Require reimbursement for collaborative, team-based MAT treatment;
- Enhance rates for MAT medication maintenance; and
- Explore new payment models for addiction treatment.

Removing Other Barriers to Prescribing of MAT Medications

The federal government and states should also take steps to remove unjustifiable barriers to MAT medications for opioid use disorder that stand in the way of widespread availability of life-saving treatment. Recommendations to remove barriers include:

- End the waiver required under DATA 2000 to prescribe buprenorphine while expanding substance use disorder education broadly;
- Eliminate patient caps under DATA 2000;
- Expand MAT within Federally Qualified Health Centers (FQHCs);
- Make permanent nurse practitioners' and physician assistants' ability to prescribe buprenorphine;
- Permit resident physicians to prescribe buprenorphine when attending physician has prescribing authority;
- Remove barriers to telehealth buprenorphine programs;
- Require 8-hour training for DATA 2000 waiver as a condition of re-licensure;

and

- Conduct analysis of providers with patient populations in need of MAT.

Improve Quality of Addiction Treatment

We must also continue to improve the quality of addiction treatment by ensuring evidence-based standards are being followed. Unless we improve quality, too many Americans will continue to die or otherwise fail to reach their full recovery. Key recommendations to improving the quality of addiction treatment include:

- Establish national licensure and accreditation standards;
- Require emergency department to initiate MAT after overdose; and
- Evaluate apps for individuals with substance use disorders.

Health Care – Broader MH/SUD Reforms

Needed reforms to our health care system, however, are not limited to those specifically tailored to medicated-assisted treatment and opioid use disorders; we must push for broader reforms within our health care system to ensure that individuals with mental health and substance use disorders receive the affordable, high-quality care they need.

Creating a System that Prioritizes Recovery

The ultimate goal of mental health and addiction treatment is recovery, which can look different for each individual and has many different paths. Mental health and addiction services in this country, therefore, should promote recovery to the maximum extent possible. The following actions would assist in this effort:

- Prioritize prevention, treatment and recovery in the federal government's efforts;
- Develop certifications for peer supports and support peer mentoring programs;
- Reimburse for peer supports;

- Ensure a continuum of effective crisis response services, including crisis respite centers;
- Invest in permanent supportive housing; and
- Expand Medicaid coverage of supported employment programs.

Ensure Screening

Early detection and treatment of mental health and substance use disorders is critical to improving long-term outcomes. Unfortunately, the United States is terrible at identifying and treating these conditions early. Just like with diseases such as cancer, diabetes, and heart disease, acting “before stage 4” is critical to long-term recovery.⁸ To promote early identification and treatment, we must take the following steps to ensure universal screening:

- Tie federal funding to training on mental health and substance use screenings;
- Require physical exams to screen for mental health and substance use;
- Report on screening rates in Medicaid;
- Tie reimbursement to providers to use of screening measurers;
- Revise CMS’s Comprehensive Primary Care Plus pilot program to include mental health; and
- Create demonstration pilot project to screen for common mental health and substance use disorders.

Integrate Mental Health and Substance Use Care with Overall Health Care

Mental health is directly connected to overall health, and the largely separate systems reflect the historic marginalization of mental health and addiction from medical and surgical care. In order to treat mental health and substance use disorders effectively and to reduce the

⁸ *The B4Stage4 Philosophy*, Mental Health America, https://www.mhanational.org/b4stage4-philosophy_

enormous human and financial costs, we must integrate mental health and addiction care with the rest of the health care system. Steps towards achieving this integration include:

- Require reimbursement of collaborative care codes;
- Enhanced CMS reimbursement for the existing behavioral health integration (BHI) and Collaborative Care Model;
- CMS to establish new G-code for a “consultation” fee;
- Expand Certified Community Behavioral Health Clinics to all states; and
- Make non-physician providers eligible for electronic health record incentives.

Eliminate Specific Medicaid/Medicare Barriers

As the most important payors in the country, Medicaid and Medicare play an enormous role in shaping overall health care policy. Therefore, it is critical to eliminate barriers within Medicaid and Medicare that inhibit treatment of mental health and substance use disorders.

Needed changes include:

- Eliminate the Medicare limit on inpatient psychiatric treatment;
- Allow Medicare Part D to cover methadone in outpatient settings;
- Use case rates to reimburse for substance use disorder care; and
- Use bundled or case rates for evidence-based care for serious mental illness such as Coordinated Specialty Care in Medicaid.

Expand Workforce

To treat mental health and substance use disorders effectively, our country must significantly increase the number of dedicated mental health and addiction providers, as well as give all clinicians the tools they need to identify mental health and substance use disorders, treat common conditions, and refer appropriately. Recommendations to expand the workforce include:

- Dramatically increase reimbursement for mental health and addiction providers, including to address existing shortages;
- Mandate mental health and addiction coursework in training programs;
- Increase funding for internships/fellowships and provide loan assistance; and
- Require telehealth to be reimbursed at parity with in-person services.

Implement Zero Suicide

It is essential that health care systems implement Zero Suicide to drive down suicides for individuals in their care (suicide prevention will be covered in more detail below). Suicide is preventable, but suicide rates continue to increase even though, of people who died by suicide, 30% had recent contact with a mental health professional and 45% had recent contact with a primary care professional.⁹

Impressive reductions in suicides have resulted from organizations that utilize the Zero Suicide approach, with common reductions of 60% to 80%.¹⁰ While health systems should implement Zero Suicide because it is the right thing to do, governments and other stakeholders should support and incentivize the implementation of Zero Suicide across the country. The federal government should require federally-administered health systems and facilities to implement Zero Suicide.

Criminal Justice System

Unfortunately, individuals with mental health and substance use disorders are disproportionately likely to become involved in our country's criminal justice system because we too often criminalize the symptoms of these conditions. People with co-occurring substance use

⁹ *Contact with mental health and primary care providers before suicide: a review of the evidence*, Div. of Services and Intervention Research, NIMH, National Institutes of Health (Jun. 2015) 159(6):909-16, <https://www.ncbi.nlm.nih.gov/pubmed/12042175>..

¹⁰ *Zero Suicide Resource*, Suicide Prevention Resource Center, <https://www.sprc.org/zero-suicide>.

disorder and a serious mental illness are 7.47 times more likely to have been arrested in the past twelve months compared to those without either condition.¹¹ Tragically, our largest places of “treatment” for people with mental health and substance use disorders are county jails. Evidence of this situation is provided by Cook County, Illinois, which has hired wardens who are mental health professionals.¹² To address this horrendous reality, we must divert people with mental health and substance use disorders from the criminal justice system wherever possible, get people currently involved in the criminal justice system the comprehensive services they need, and ensure that people who are leaving incarceration receive the ongoing services they need for successful reentry into communities.

Ensure Mental Health and Addiction Treatment During Incarceration That Meets Constitutional Standards

Jails and prisons are not where treatment *should* happen, but in our current system, far too many people with mental health and substance use disorders are inappropriately incarcerated. About half of all people in state and federal prisons have substance use disorders, but there is shockingly low utilization of medication-assisted treatment in all criminal justice settings.¹³ While we must work to end inappropriate incarceration, we must also provide individuals who are incarcerated with the services they need to treat their mental health and substance use disorders.

Under the Eighth Amendment to the U.S. Constitution, which prohibits cruel and unusual

¹¹ *Risk of criminal justice system involvement among people with co-occurring severe mental illness and substance use disorder*, Silberman School of Social Work, City University of New York, USA (May-Jun. 2018) 58:1-8, <https://www.ncbi.nlm.nih.gov/pubmed/29852999>.

¹² Nader Issa, *Cook County Jail hires 2nd consecutive mental health professional as warden*, CHI. Sun Times, Mar. 6, 2019, <https://chicago.suntimes.com/2019/3/6/18435710/cook-county-jail-hires-2nd-consecutive-mental-health-professional-as-warden>.

¹³ *Medications to Treat Opioid Use Disorder*, National Institute on Drug Abuse (Jun. 2018), <https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/how-opioid-use-disorder-treated-in-criminal-justice-system>.

punishment, prisoners have a constitutional right to adequate medical care¹⁴ – including for mental health and substance use disorders.¹⁵ For jails and prisons to meet their constitutional obligations to incarcerated individuals needing mental health and addiction treatment, the following steps should be taken:

- Require all jails and prisons to have treatment programs;
- Ensure all care recommended by clinicians is provided;
- Eliminate federal Bureau of Prisons exclusion of MAT;
- Include mental health and addiction training in criminal justice disciplines;
- Penalize states that terminate rather than suspend Medicaid eligibility during incarceration; and
- Ensure successful reentry upon release.

Divert Wherever Possible and Reduce Impacts of Prior Convictions

Our country must do everything possible to divert people with mental health and substance use disorders from ever entering the criminal justice system. Once in the system, multiple off ramps of diversion should be provided to avoid criminal justice system involvement and the harm associated with such involvement. This harm is significant. Individuals who become involved in the criminal justice system experience trauma, worsening of their conditions, and an inability to access many public services. Criminal justice involvement makes it hard to find and keep a job, and it contributes to homelessness. It wastes public dollars. Not surprisingly, the high U.S. incarceration rates are associated with increased deaths from

¹⁴ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

¹⁵ Anita Marton and Gabrielle de la Gueronniere, “Recent Court Actions Impacting the Substance Use Disorder Field,” *Legal Action Center*, 2019, <https://nasadad.org/wp-content/uploads/2019/06/6.6.19-Recent-Court-Actions-Impacting-SUD-Field.pdf>.

substance use disorders.¹⁶ In short, there is no benefit from needless criminal justice system involvement. To avoid such involvement, all levels of government should:

- Train law enforcement to avoid arrests and criminal charges wherever possible in cases of individuals who are having a mental health crisis;
- Ensure screenings of those who become involved with the criminal justice system for mental health and substance use disorders;
- Coordinate services between levels of government and community organizations;
- Allow voluntary treatment to avoid charges;
- Defer criminal proceedings during treatment if prosecution is deemed necessary;
- Expand mental health and drug courts and do not require guilty pleas;
- Expunge criminal records upon successful treatment;
- End counterproductive cutoffs from public programs; and
- Fix incentives that encourage local governments to send people to state prisons.

Pregnant Women, New Mothers, and Newborns with Opioid Dependence

There has been a large increase in children with neonatal abstinence syndrome (NAS), which results when a newborn is suddenly discontinued substances to which the newborn was

¹⁶ Elias Nosrati, Ph.D., Jacob Kang-Brown, Ph.D., Prof. Michael Ash, Ph.D., Prof. Martin McKee, M.D., Prof. Michael Marmot, M.D. and Prof. Lawrence P. King, Ph.D., *Economic decline, incarceration, and mortality from drug use disorders in the USA between 1983 and 2014: an observational analysis*, Vol. 4, Issue 7, PE326-E333, The Lancet (Jul. 1, 2019), [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(19\)30104-5/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30104-5/fulltext).

exposed during pregnancy.¹⁷ In areas hard hit by the opioid crisis, increases in youth in foster care are strongly tied to rising overdose death rates.¹⁸ Nationwide, the number of children in foster care increased 10%, or nearly 40,000 children, between 2012 and 2016. These children have often experienced enormous trauma associated with parents' substance use disorders and, frequently, deaths. The following recommendations can help address these disturbing trends and help mothers with opioid use disorder:

- Prioritize treatment and research of substance use disorders among women who are pregnant or likely to become pregnant;
- Connect pregnant women with opioid use disorder with treatment;
- Expand NAS intensive care units;
- Fund research to prevent and treat NAS more effectively;
- Increase child welfare program appropriations; and
- Modernize child welfare systems.

Education

Our country's education system must prioritize prevention, screening, and age-appropriate mental health and addiction services for children and young adults, both in the preK-12 system and in higher education. This is particularly important because 50% of mental illnesses develop by age 14, and 75% develop by age 24.¹⁹ Without early identification and

¹⁷ Sean Lynch, Laura Sherman, Susan M. Snyder and Margaret Mattson, *Trends in infants reported to child welfare with neonatal abstinence syndrome (NAS)*, Children and Youth Services Review, Vol. 86 (P. 135-141) (Feb. 22, 2018), <https://www.sciencedirect.com/science/article/pii/S0190740917308265>.

¹⁸ Laura Radel, Melinda Baldwin, Ph.D., Gilbert Crouse, Ph.D., Robin Ghertner and Annette Waters, Ph.D., "Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study", *ASPE Research Brief, U.S. Department of Health and Human Services* (Mar. 7, 2018), available at <https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf>.

¹⁹ Kessler, Berglund, et. al, "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, July 2005, <https://www.ncbi.nlm.nih.gov/pubmed/15939837>.

treatment, outcomes significantly worsen.

PreK-12

Children on average spend six or more hours a day in school, making it an important locus of age-appropriate mental health and addiction services. By improving identification and providing services early on, we improve the long-term health of our children into adulthood and increase their overall success. To improve our children's mental health, the U.S. preK-12 education system should:

- Ensure students can access a continuum of mental health services;
- Make schools a hub of wellness services;
- Increase funding for school counselors, nurses, and psychologists;
- Have payors reimburse school-based mental health services; and
- Train school personnel to improve mental health literacy.

Higher Education

Colleges and universities also have a critical role to play in improving the mental health of young people. This is particularly important during young people's transition into higher education. To improve students' mental health, our country must do the following:

- Fully fund campus mental health and substance use services under the 21st Century Cures Act;
- Tie federal financial assistance to colleges having mental health programs;
- Amend the Higher Education Act to better serve students with disabilities, including mental health conditions;
- Provide guidance and best practices to colleges on complying with federal disability law;

- Clarify that federal Student Support Services funding can fund mental health counseling services;
- Increase transparency in colleges' use of mental health-related grant funding; and
- Develop policies, protocols, and practices relating to mental health and substance use disorders that support students and avoid discrimination.

Suicide Prevention

Tragically, suicide continues to increase. Over the last two decades, suicide rates have increased by one-third. Suicide is now the 10th leading cause of death in the United States and became the 2nd leading cause of death for young people ages 10 to 34 in 2016.²⁰ Each year between 2008 and 2017, over 6,000 veterans have died by suicide. That's more than 60,000 deaths over the 10-year period.²¹ To reduce suicides, we must:

- Limit access to firearms and other means;
- Fully implement the new 988 suicide and mental health crisis hotline;
- Prioritize suicide prevention research;
- Robustly fund the National Violent Death Reporting System to collect data in a more timely fashion;
- Create suicide prevention plans in all 50 states;
- Require training on suicide prevention for health professionals; and
- Require schools to have non-punitive suicide prevention policies.

²⁰ Holly Hedegaard, M.D., Sally C. Curtin, M.A., and Margaret Warner, Ph.D., *Suicide Mortality in the United States*, 1999-2017, NCHS Data Brief, No. 330 (Nov. 2018), <https://www.cdc.gov/nchs/products/databriefs/db330.htm>.

²¹ U.S. Department of Veterans Affairs, "2019 National Veteran Suicide Prevention Annual Report," 2019, https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf.

Meet the Needs of Specific Populations

While mental health and addiction challenges affect all communities, many communities are less likely to get the services they need and/or are at higher risk for mental health and addiction challenges due to discrimination, marginalization, and trauma, as well as – in the case of veterans – the unique characteristics of their service.

Racial/Ethnic Minorities

Though many racial and ethnic minorities (including Blacks, Asians, and Hispanics) actually have a lower incidence of mental health disorders than whites, people in these groups with a mental health disorder access mental health services at a lower rate than whites – roughly one-third of Blacks and Hispanics and only one-fifth of Asians. Outcomes for people in these groups are often also worse. For example, though Blacks and Asians have lower rates of depression, their depression is likely to be more persistent. Furthermore, Blacks make up a disproportionate proportion of those in the criminal justice system, where the incidence of mental health and substance use disorders is much higher than the general population.²² There has also been a disturbing increase in suicide rates for Black children and youth in recent years. Between 2007 and 2017, the suicide rate for Black youth nearly doubled from 2.55 to 4.82 suicides per 100,000.²³ Native Americans / Alaska Natives have been disproportionately affected by the opioid and suicide epidemic, which is in part attributable to intergenerational trauma.

Additionally, Native American / Alaska Native youth have the highest rate of major depressive

²² *Mental Health Disparities: Diverse Populations*, American Psychiatric Association (2017), <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Diverse-Populations.pdf>.

²³ Rep. Bonnie Watson, Task Force Chair, RING THE ALARM THE CRISIS OF BLACK YOUTH SUICIDE IN AMERICA, A Report to Congress From The Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf Taskforce on Black Youth Suicide and Mental Health, https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf.

episodes than any other racial and ethnic group.²⁴

Of course, the ultimate solution to these large inequities is eliminating structural racism in every aspect of our society – e.g., housing, education, employment, transportation, and health care – and ensuring equitable opportunities for people of all racial and ethnic backgrounds. While we work towards these broader systemic changes, we should pursue policies that do the following to increase access to high-quality mental health and addiction treatment for racial and ethnic minorities:

- Ensure all Americans have access to comprehensive, affordable insurance coverage;
- Increase diversity among mental health and addiction providers in order to provide culturally and linguistically-competent care;
- Allocate research dollars to study specific populations;
- Locate treatment providers in the areas of greatest need;
- Recognize and treat the effects of trauma;
- Build upon community beliefs and systems; and
- Ensure sovereign tribes can access all grant opportunities.

Veterans

As mentioned above, more veterans have died from the “individual wounds of war” than were killed in action in Iraq and Afghanistan. Between 11 to 20% of veterans who served in Iraq and Afghanistan have post-traumatic stress disorder (PTSD) in a given year.²⁵ More than 1 in 10

²⁴ *Mental Health Disparities: American Indians and Alaska Native*, American Psychiatric Association (2017), <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf>.

²⁵ National Center for PTSD, U.S. Department of Veterans Affairs, https://www.ptsd.va.gov/understand/common/common_veterans.asp.

adults who are homeless are veterans.²⁶ To get veterans the help they deserve, we must:

- Expand mental health and substance use screenings among returning veterans;
- Extend National Health Service Corps to include VA facilities;
- Increase funding for programs that support veterans;
- Increase VA funding for mental health professionals;
- Expand outreach strategies to engage veterans;
- Ensure availability of evidence-based interventions for PTSD and other mental health conditions throughout the VA system;
- Expand coverage for health, mental health and substance use conditions to all veterans;
- Expand the availability of tele-mental health; and
- Implement peer support programs, including those that support military caregivers, such as NAMI's *Homefront* program.

LGBTQ

Approximately 4 in 10 LGBTQ youth have seriously considered suicide in the previous 12 months, with more than half of transgender / non-gender-binary youth having seriously considered suicide. Youth who have had to undergo “conversion therapy” to change their sexual orientation or gender identity had double the rate of suicide attempts, with 57% transgender and non-binary youth subjected to conversion therapy having attempted suicide in the past year.²⁷ To improve the mental health and well-being of LGBTQ youth, we must:

²⁶ National Institute on Drug Abuse, “General Risk of Substance Use Disorders,” October 2019, <https://www.drugabuse.gov/publications/drugfacts/substance-use-military-life>.

²⁷ Amit Paley, *National Survey on LGBTQ Youth Mental Health*, The Trevor Project (2019), <https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results-2019.pdf>.

- Ban conversion therapy;
- Create safe and supportive school environments; and
- Support homeless youth programs and require safe environments.

Workplace

Employers are increasingly recognizing the impact of poor mental health in the workplace and the need to have meaningful responses to improve the health of their employees, which is essential to organizational performance. With approximately one-third of working-age adults experiencing a mental health disorder at some point, these conditions make up the largest percentage of health care costs for many employers, regardless of industry.²⁸ To realize the \$3 to \$5 return on investment for every dollar that employers invest in workplace mental health²⁹, the following are necessary:

- Build commitment among organizational leaders to promote mental health in the same way as physical health;
- Measure workplace mental health and commit to proactive prevention and early intervention;
- Pursue market-driven plans to improve mental health and addiction treatment;
- Ensure that employer-based health insurance provides affordable in-network coverage for needed mental health and substance use services;
- Implement programs like Mental Health America's Bell Seal for Workplace Mental Health to acknowledge workplaces that meet quality standards; and

²⁸ *ONE MIND at WORK, Fact Sheet: The High Cost of Mental Disorders – Facts for Employers* (Dec. 2018), <https://onemindatwork.org/wp-content/uploads/2018/12/Updated-Employer-Fact-Sheet.pdf>.

²⁹ Creating a mentally healthy workplace: Return on investment analysis. PwC, beyond blue, Australian Government National Mental Health Commission, and The Mentally Healthy Workplace Alliance. Available at: https://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf.

- Create technical assistance centers for workplace mental.